Therapeutic interventions with child and adolescent survivors of sexual abuse

Therapeutic Interventions with Child and Adolescent Survivors of Sexual Abuse: A Critical Narrative Review

Abstract

This is a narrative review of literature on therapeutic interventions with child and adolescent survivors of childhood sexual abuse (CSA). This is a step towards investigating the existing evidence-base for the therapeutic interventions, including various approaches to therapy and modalities, practiced by professionals with child and adolescent survivors of CSA. The key objective of this review was to examine treatment outcomes, established evidence-base and gaps in extant knowledge of different therapeutic interventions documented as being practiced within this population for CSA trauma. A number of individual studies, systematic reviews and meta-analyses were identified through a wide range of databases, including appropriate reference search. Findings reflected an absence of culturally-specific, clear guides to therapy for CSA survivors, particularly for child and adolescent survivors. Further, inconclusive, conflicting and contradictory evidence-base of therapeutic approaches, with limited scope and methodological flaws, was revealed. Based on these findings, it is argued that the factors that inform decisions regarding the therapeutic practice of practitioners, including mental health professionals, in real settings with child and adolescent survivors of CSA are not clearly defined and often take place in absence of a coherent and consistent evidence-base for existing therapeutic practices documented for CSA. Implications for research and practice are discussed.

Key words: *Child sexual abuse, therapeutic interventions, trauma treatment, cultural context, child and adolescent survivors of sexual abuse, evidence-base*

1. Introduction

Adverse childhood experiences (ACEs), such as physical abuse, neglect, and childhood sexual abuse (CSA), are the main determinants of relational, physical and social well-being and an important public health issue (ScotPHN, 2016). They can have profound impact on survivors' mental and physical health even after fifty years of their occurrence (Lanius et al., 2010). CSA is defined as, *"The involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to: the inducement or coercion of a child to engage in any unlawful sexual activity; the exploitative use of a child in prostitution or other unlawful sexual practices; the exploitative use of children in pornographic performance and materials*" (WHO, 1999). CSA is widely prevalent internationally and tends to be largely under-reported (WHO, 2014). Pereda and colleagues reviewed 39 international epidemiological studies in 21 countries on the prevalence of CSA, using a broad definition of the phenomenon (n = 65 - 9,953, mean n = 1647), and reported its prevalence to be up to 60% for males and up to 53.2% for females across studies (Pereda et al., 2009). Children and adolescents worldwide are affected by it, irrespective of age, gender, race, ethnicity, socio-economic status, religion or disability (Greenspan et al., 2013).

Despite its impact on health, CSA is not a health condition per se. There is however an overlap between complex trauma and CSA, as its survivors can develop complex trauma. Complex trauma is defined as "*a type of trauma that occurs repeatedly and cumulatively,*

usually over a period of time and within specific relationships and contexts." Examples include severe child abuse, domestic abuse, or multiple military deployments into dangerous locales' (Courtois et al., 2009). In recognition of the distinct characteristics and mental health needs of survivors, complex trauma, CSA included, is now a new diagnostic category in the International Classification of Disorders (ICD-11) (Knefel et al., 2019).

CSA can have a pervasive and long lasting impact on the health and wellbeing of survivors, which extends and last through adulthood. CSA is a major cause of poor mental health (Molnar et al., 2001), functional disability, high utilization of health services, physical health, and poor subjective health, and as a result higher use of psychiatric services than the rest of the population (Cohen et al., 2008). Overall, more studies are concluding that children with sexual abuse trauma suffer from higher physical and psychological difficulties and symptoms than those who are not sexually abused (Kendall-Tackett et al., 1993; Saied-Tessier, 2014) as well as those with other non-sexual forms of traumatic experience (Palo & Gilbert, 2015). Saied-Tessier (2014) based on the review of different studies reported depression, suicide and self-harm to be two and three-times higher respectively in sexually abused children compared with those with no sexual abuse experience. Further, research reveals that almost half of female psychiatric inpatients, i.e. 48% (Read et al., 2007) and 50-75% of adult female patients including inpatient and outpatient settings (Courtois, 1997) have histories of sexual abuse in childhood. Among women and men survivors of CSA, an increase in suicide attempts have been found compared with those without a history of sexual abuse in childhood (Clayton, 2004). Further, CSA has a severe impact on resources, for example, it costs the UK £3.2bn a year, in terms of healthcare, criminal justice service, and loss of productivity (Saied-Tessier, 2014).

Impact of CSA on Child & Adolescent Survivors

Physical	Behavioural	Psychological	Cognitive Distortions	Interpersonal & Social Difficulties	Body & Sexuality	Psychiatric Disorders
- Teenage pregnancy - Sexually Transmitted infections/ HIV - Actual physical damage -Psychosomatic manifestations - Gastro intestinal & genitourinary disorders - Headaches - Chronic pain disorders: fibromyalgia - Neurological problems	-Internalising behaviour -Externalising behaviour - Aggression - Self harm - Suicide - Substance use - Sexual behaviour problems - Running away - Academic difficulties -Occupational dysfunction - Social exclusion/ avoidance - Criminal activity/ Anti- social behaviour	- Depression - Anxiety - Low self-esteem - Altered sense of self - Guilt - Self blame - Fear - Aggression - Post-traumatic stress - Sleep - disturbance - Dissociation - Altered emotionality - Impaired self-reference	- Impact on overall information and thought processing including abuse - perceptions, beliefs, and value-systems - Distorted views about self and the world	- Poor or disorganized attachments - Lack of trust - Feelings of betrayal - Difficult relationships - Social withdrawal - Sexual exploration/ aversion - Tendency to be revictimised	- Altered sense of body - 'damaged goods syndrome' - Sexualised or sexually withdrawn - Gendered impact: confused sense of femininity/ masculinity	- PTSD - Depression - Anxiety disorders - Mood disorders Dissociative disorders - Eating disorders - Sleeping problems - Substance abuse disorders

Figure 1. Impact of CSA on Children and Adolescents

Rationale for the Review: Need to focus on Therapeutic Interventions for Child and Adolescent Survivors of CSA

Although the impact of CSA is profound, it is noted that there is no specific 'CSA syndrome' or 'post-abuse syndrome' (Kendall-Tackett et al., 1993; Mullen & Fleming et al., 1998). Some child survivors may display a variety of symptoms but no single symptom may be displayed by others (Coren et al., 2009). Approximately about one-third of survivors do not show any symptoms and some symptoms are specific to certain ages (Kendall-Tackett et al., 1993), and some may be affected much later in life, referred to as sleeper effect (Briere, 1992; Macdonald et al., 2012). Further, CSA survivors are also known to be prone to sexual revictimization (Lalor & McElvaney, 2010). The variation in the impact of CSA in children and adolescents is found to be mediated by various factors. These include, but not limited to, characteristics of abuse experience (duration and frequency of abuse, proximity to the

perpetrator); negative internalizations and attributions about self and the world (including shame and self-blame), negative coping patterns, and interpersonal difficulties including insecure attachments (Kendall-Tackett et al., 1993; Whiffen & Macintosh, 2005). Finally, developmental stage and age of the child at the time of abuse determines the difficulties manifested and extent of long-term consequences experienced (Macdonald et al., 2012; Mullen & Fleming, 1998; Ross & O'Carroll, 2004).

Hence, the impact of CSA is noted to be variable, complex and multifaceted, and varies with the developmental stage and age of the child, which makes the survivors of CSA a heterogeneous group with varied needs and presentations for therapeutic support and interventions (Berliner & Saunders, 1996; Cohen, 2008; Lalor & McElvaney, 2010; Mullen & Fleming, 1998). Besides, sexual abuse rarely occurs in isolation, which is partly responsible for heterogeneous nature of CSA (Parker & Turner, 2013). In a recent evaluation, over half of older children and young people and around one third of young children (under 8 years) who participated in the study had experienced three or more types of abuse in addition to sexual abuse (Carpenter et al., 2016). These factors raise the risks of higher mental health difficulties due to poor attachments, lack of care and parental strains (Trowell et al., 2002). Further, causes, risk factors and impact of CSA are influenced by specific socio-cultural context of survivors. This heterogeneity and differential impact of CSA on children and adolescents triggered the need to review documented therapeutic interventions for this population, their effectiveness and evidence-base in order to understand the factors that inform therapeutic practice by different professionals/therapists in different cultural and country contexts.

Although treatment outcome studies are limited (Finkelhor & Berliner 1995; Ross & O'Carroll, 2004), a large consensus has been found in existing empirical studies suggesting

therapy facilitates recovery for child and adolescent survivors of CSA and that it is better than no treatment and/or being on a wait-list (e.g. Finkelhor Berliner 1995; Greenspan et al., 2013; Hetzel-Riggin et al., 2007; Lanktree & Briere, 1995; Passarela, Mendes, & Mari, 2010; Ross & O'Carroll, 2004; Sánchez-Meca, Rosa-Alcázar, López-Soler, 2011; Skowron & Reinemann, 2005). The availability of large number of therapeutic approaches, models and modalities for sexual abuse survivors in itself is considered to be indicative of the benefits of therapy for alleviating symptoms and negative sequelae associated with CSA (Berliner & Saunders, 1996). Therapy not only leads to improvement in post-traumatic and other psychological symptoms associated with CSA (Lanktree & Briere, 1995), but also prevents development of future difficulties and symptomatology (Springer, Misurell, & Hiller, 2012), as well as revictimization and recidivism (Duffany & Panos, 2009). In a meta-analysis on effectiveness of psychological interventions for child maltreatment, including survivors of sexual abuse, Skowron and Reinemann (2005) reported significant improvements in 71% children who received therapy compared with those who received no treatment. Further they reported that treatment increased the improvement rate by 28% while children who were not offered therapy deteriorated over a two-year period (Springer et al., 2012). Studies that compared CSA-treatment outcomes with a controlled group of untreated survivors found outcomes to be positive for both boys and girls as well as for children with disabilities such as deafness (Sullivan, Scanlan, Brookhouser, Schulte, and Knutson, 1992). Therapy is also reported to be beneficial for non-offending or safe parents/carers (e.g. Cohen et al., 2006; Cohen & Mannarino, 1996, 1998; Deblinger, Lippman, & Steer, 1996; Deblinger, Steer, Lippman, 1999) as well as in improving relationship between them and the child survivors (Tourigny et al., 2005). In intrafamilial abuse, if the perpetrator is one of the parents, the other parent is referred to as a non-offending or safe parent (Macdonald et al., 2012).

Given the evidence regarding severe and long-lasting risks associated with CSA and benefits of treatment for sexually abused children and adolescents, the significance of early intervention is considered to be vital (Greenspan et al., 2013; Lev-Weisel, 2008; Sánchez-Meca et al., 2011; Trask et al., 2011). It reinforces the need for identification and application of "most effective" treatment (Cohen, Deblinger, Mannarino, and Steer, 2004, p. 401) for this population.

For this narrative review, therapeutic Interventions for CSA were defined as *'those interventions that intervene with children and young people and their families and carers, to reduce the longer term symptomatic impact of the experience of trauma resulting from sexual abuse" (Coren et al., 2009), and 'any intervention designed to alleviate psychological distress, reduce maladaptive behavior, or enhance adaptive behavior through counselling, structured or unstructured interaction, a training program, or a predetermined treatment"* (Weisz, Weiss, Alicke, and Klotz ,1987; p. 543). The review focused on two intersecting categories of evidence of therapeutic interventions, i.e. evidence on therapeutic approaches including the evidence on length of treatment as well as evidence on therapeutic modalities.

2. Aims of the Review

- To examine therapeutic interventions, including approaches to therapy and modalities, documented in extant literature as being practiced with child and adolescent survivors of CSA.
- To review and summarize narratively existing evidence-base, cultural relevance and gaps in the utilization and effectiveness of various therapeutic interventions.

3. Method

A number of databases were searched for the literature sources including ASSIA, CINAHL, Child Development & Adolescent Studies, Cochrane Library, EMBASE, MEDLINE, National Institute for Health and Clinical Excellence (NICE) Clinical Guidelines, PILOTS, PsycINFO, Pubmed as well as Google Scholar and the University of Edinburgh Searcher. In addition to individual studies, systematic reviews and meta-analyses were identified and analyzed to examine the treatment outcomes and evidence-base of different therapeutic approaches and modalities. Appropriate references from the accessed articles were sourced when required to ensure a comprehensive review of extant literature.

Search terms included child sexual abuse, trauma, treatment, therapeutic approaches, therapy modalities, psychotherapy, interventions, effectiveness, evidence-base, or cultural relevance. Each article identified using these search terms was manually inspected for relevance. Inclusion criteria included studies published in English over past four decades, i.e. between 1985 and 2018. Approximately 260 articles were gathered through the initial search. The search strategy excluded grey literature. While reviews and meta-analyses were included, studies were excluded from the present review if they were included in a previous review of meta-analyses. All the articles that focused on child and adolescent survivors of CSA were thoroughly examined, and each article was coded based on the aims of the review.

4. Key Findings and Learnings

4.1 Range of Therapeutic Approaches, Models and Modalities

The review revealed that a range of therapeutic approaches and treatment modalities for CSA are enumerated in the literature (Allnock & Hynes, 2012; Cohen, Mannarino, &

Knudsen, 2005; Finkelhor & Berliner, 1995**;** Lev-Wiesel, 2008; Misurell, Springer, & Tryon, 2011). Therapeutic approaches differ in structure, content and impact, and are based on varying theoretical constructs (Cohen, Mannarino, *&* Deblinger, 2006; Lev-Wiesel, 2008; Reavey & Warner, 2001), such as psychoanalytic and psychodynamic theories, behavioral and cognitive behavioral, social learning, attachment, humanistic including person/child centered and gestalt (Nelson-Jones, 2011), developmental, and feminist (Avinger & Jones, 2007; Coren et al., 2009; Keller et al., 1989; Misurell et al., 2011; Reavey & Warner, 2001). Some of the approaches seem to be practiced mostly with child and adolescent survivors such as play therapy, whereas others are used with adults as well. The practice ranges from psychoeducation, screening, short-term abuse-focused therapy to more comprehensive long-term and/or stage-based therapeutic plans, approaches and models (Saywitz, Mannarino, Berliner, & Cohen, 2000), using different treatments modalities such as individual, family and group therapies practiced exclusively or in combination (Cohen et al., 2006; Dietz, Davis & Pennings, 2012; Lev-Wiesel, 2008; Tourigny, Hébert, Daigneault, & Simoneau, 2005).

The key findings and learnings from the narrative review of literature regarding different therapy approaches and models, therapeutic modalities, and overall gaps and challenges in research and practice of CSA therapy with child and adolescent survivors are discussed in subsequent sections.

4.2 Therapeutic Approaches: Evidence-Base and Gaps in Knowledge and Practice

4.2.1 Limited evidence-base and gaps in knowledge and practice of therapeutic approaches.

The benefits of therapy in facilitating recovery from CSA have been found; however

there seems to be a lack of significant support for one treatment approach over another (Coren et al., 2009; Finkelhor and Berliner; 1995; Harvey, & Taylor, 2010). This is because few therapies for child and adolescent survivors of CSA have been evaluated with sound scientific rigor and methodology (Berliner & Saunders, 1996; Cohen et al., 2006; Cohen & Manna rino, 1996; Kazdin & Weisz, 1998; Misurell et al. 2011; Ross & O'Carroll, 2004; Skowron & Reinemann, 2005). Further, an absence of psychological conceptual framework for comprehending and treating abuse-related trauma symptoms and difficulties (Ross & O'Carroll, 2004) and lack of clear treatment protocols (Lev-Wiesel, 2008) have been reported. There is a lack of consensus on treatment characteristics (Hetzel-Riggin et al., 2007) and/or treatment guidelines for child and adolescent sexual abuse therapy (Hetzel-Riggin et al., 2007). Developing uniform guidelines for CSA-therapy is considered to be challenging due to the associated complexities and heterogeneity of CSA (Glaser, 1991; Glaser & Wiseman, 2000).

There has been a growing focus on providing evidence-based therapeutic interventions in all fields including social work, health care (Webb, 2001), and treatment for CSA survivors (Denton, Walsh, & Daniel, 2002; Jones & Ramchandani, 1999). Evidence-based practice is described as "*the selection of treatments for which there is some evidence of efficacy*" (Denton et al., 2002, p. 40). Randomized Controlled Trails (RCTs) are considered to be the 'Gold Standard' for evidence-based treatment trials, which include randomly assigning selected participants to well-defined treatments, including an index treatment group compared with an alternative treatment or wait-list control group (Cohen et al., 2005; Cohen et al., 2004).

Overall empirical controlled studies on effectiveness of different therapy approaches for children and adolescents in general, and CSA survivors specifically, are reported to be

limited (Allnock & Hynes, 2012; Ramchandani & Jones, 2003; Saywitz et al, 2000; Misurell et al., 2011; Springer et al., 2012). Although some researchers posit that there is an increase in empirical evaluation studies over the past decade (Cohen et al., 2004), these have been found to be limited to cognitive-behavioral therapy (CBT) and trauma-focused CBT (TF-CBT). Other psychotherapy approaches, including psychodynamic therapy, family therapy, child-centered therapy, play therapy, or other structured group treatment modalities have not been well evaluated (Cohen, 2008; Lev-Wiesel, 2008; Saunders et al., 2003). CBT, including TF-CBT are considered to be frequently studied in efficacy studies as they are shorter in duration and easy to manualize, standardize and use in structured, controlled treatment trials (Coren et al., 2009; Saywitz et al., 2000) such as RCTs.

4.2.2 Effectiveness of therapeutic approaches: inconclusive evidence.

Due to higher number of empirical studies on CBT and TF-CBT compared to other therapy approaches, these seem to be the most effective interventions for child and adolescent survivors of CSA at the first instance (Greenspan et al., 2013; Jaberghaderi, Greenwald, Rubin, Zand, & Dolatabadi, 2004; Ramchandani & Jones, 2003; Kings et al., 1999). However, these claims are not sustained when a range of studies and reviews were analyzed, as discussed below:

CBT, TF-CBT and other structured approaches.

Although limited, existing individual RCT studies on CBT-based approaches emphasize their effectiveness in improving a wide range of trauma symptoms in young children who have experienced sexual abuse. These studies include CBT in general (i.e. Deblinger et al., 1996, 1999; Kings et al., 2000); CBT for sexually abused pre-school

children (i.e. CBT-SAP/Cohen & Mannarino, 1996, 1997); Sexual-abuse specific CBT (i.e. SAS-CBT/Cohen & Mannarino, 1998); and TF-CBT (i.e. Cohen et al., 2004; Cohen et al., 2005; Deblinger, Mannarino, Cohen, & Steer, 2006; Deblinger, Mannarino, Cohen, Runyon, & Steer, 2011; Mannarino, Cohen, Deblinger, Runyon, & Steer, 2012). Most of these approaches have been developed and evaluated by the researchers themselves. CBT and TF-CBT were found to be superior and statistically significant in alleviating symptoms associated with CSA compared with other controlled treatment conditions such as non-directive supportive therapy (i.e. Cohen & Mannarino, 1996, 1997, 1998; Cohen et al., 2005), child-centered therapy (i.e. Cohen et al., 2004; 2006); standard community care (i.e. Deblinger et al., 1996, 1999) and wait-list control condition. These were also reported to be efficient in reducing post-traumatic stress disorder (PTSD) symptoms as quickly as possible (i.e. Deblinger et al., 2006) with sustained improvements over 3 month, 6 months, one and two years periods after treatment completion (i.e. Cohen & Mannarino, 1996, 1997; Cohen et al., 2005; Deblinger et al., 1996, 1999, 2006; Mannarino et al., 2012). Few of these studies also report the efficacy of CBT with pre-school or very young children, aged 2-6 years (i.e. Cohen & Mannarino, 1996, 1997; Deblinger et al., 2011; Deblinger, Stauffer, & Steer, 2001). Cohen & Mannarino (1996) found behavioral interventions better for pre-school children than play therapy, especially for sexually inappropriate behaviors. The effectiveness of CBT for reducing PTSD symptoms in sexually abused children was also confirmed in a systematic review (i.e. Passarela et al., 2010). Furthermore, all of the above studies also included non-offending parents and caregivers. All these studies found greater improvement in parents assigned to CBT or TF-CBT specifically for relieving abuse-specific distress, increasing support for the child, and overall parenting practices. However, significant differences in the efficacy of CBT for children with or without parental engagement were not found (i.e.

Deblinger et al., 1996, 1999; Kings et al., 2000). Other non-RCT, pre and post treatment design studies on structured cognitive and behavioral based approaches report similar improvements in children and non-offending parents/caregivers post-treatment and at 1-2 year follow up. These include stress inoculation and exposure treatment (i.e. Berliner & Saunders, 1996) and relatively newer treatments such as group-based CBT (i.e. GB-CBT/Misurell et al., 2011; Springer et al., 2012). Based on the evidence of effectiveness of TF-CBT, it is also clinically accepted for treating the sequelae of PTSD, CSA included, in children and adolescents. For example, the National Institute for Health and Care Excellence (NICE), UK recommends TF-CBT for adults as well as children and young people with PTSD, which includes sexual assault and childhood abuse among the causal factors (NICE, 2005, 2018) as well as in its guideline on therapeutic interventions specifically for children, young people and families after sexual abuse (NICE, 2017).

However, researchers caution against accepting conclusions regarding the effectiveness of CBT just because it is frequently evaluated, and consider it as one of the challenges of evaluating the evidence-base for psychotherapy (Carr, 2006; Lalor & McElvaney, 2010). This caution seems to be legitimate, as evidence contrary to the above studies has been found in this review.

The results on the effectiveness of CBT were not found to be statistically significant in two meta-analyses (i.e. Macdonald et al., 2012; Macdonald, Higgins & Ramchandani, 2006). Both these meta-analyses reported moderate effects in the areas of PTSD and anxiety symptoms reduction for which CBT has been considered to be highly effective in most individual studies. The need for more carefully conducted and better-reported trials on CBT has been suggested in these meta-analyses. Other reviews echo these findings. The evidence in favor of CBT is considered to be “more equivocal than some reviewers would suggest,

including those who have themselves conducted trials" (Parker & Turner, 2013, p. 4). Consistent with the findings of Macdonald et al. (2012, 2006), other meta-reviews and meta-analysis that compared CBT with different treatment approaches, indicated that the evidence for effectiveness of CBT is less robust than had been previously assumed and it may not be useful for all children and adolescents (i.e. Coren et al., 2009; Saunders et al., 2003). Even one of studies that reported the effectiveness of TF-CBT indicated clinical concerns about its structured and relatively fast-pace nature that may overwhelm some sub-groups of children (i.e. Deblinger et al., 2006). Effectiveness of CBT for younger children has also been questioned (e.g. Greenspan et al., 2013). Further, there are differences between CBT and TF-CBT as therapeutic approaches, with a trauma narrative component or gradual exposure to the traumatic experience being central to the latter and absent in former. However, it is unclear which of these two approaches is more effective than the other (Greenspan et al., 2013).

At the same time, effectiveness of other structured therapeutic approaches for CSA-therapy has been reported, although studies were found to be limited. For example, a study that compared effectiveness of CBT with Eye Movement Desensitization and Reprocessing (EMDR) with sexually abused girls in Iran (i.e. Jaberghaderi et al., 2004) found positive outcomes with both these approaches for PTSD & behavior problems. On the contrary, EMDR was considered more efficient in achieving these outcomes in less time compared with CBT. In a pilot study, Weiner, Schneider, and Lyons (2009) found TF-CBT, child-parent psychotherapy and structured psychotherapy equally effective in improving traumatic stress symptoms, behavioral and emotional needs, and child's strengths across racial groups (including white, African-American, Hispanic and biracial populations) of children exposed to trauma. These studies also point towards cultural relevance of these therapies.

Non-directive approaches.

RCTs of other treatment approaches and models are reported to be rare (Cohen et al., 2004) or completely non-existent. However, researchers suggest several therapeutic approaches include "significant therapeutic components that may contribute to therapeutic change above and beyond TF-CBT" (Misurell et al. 2011, p. 16), and have been considered to be effective for improving symptomatology associated with CSA in children and adolescent (Greenspan et al., 2013). In this section, studies identified on different non-directive therapeutic approaches including psychodynamic therapy, play therapy, art therapy, and animal assisted therapy have been discussed.

No RCTs were found on psychoanalytic/psychodynamic psychotherapy in the recent review by Parker and Turner (2013). Referring to it as a treatment of choice for many health professionals, they emphasize that an absence of RCTs "does not mean that the intervention (psychodynamic) does not work in this population" (p. 12) referring to child and adolescent survivors of CSA. Two active comparison design studies on the psychodynamic therapy (i.e. psychodynamic compared with Behavioral Reinforcement Therapy by Downing, Jenkins, & Fisher, 1988; & brief focused psychoanalytic individual therapy compared with psychoeducational group therapy by Trowell et al., 2002) found it effective, particularly for reducing PTSD symptoms and increasing adaptive functioning. Even though the sample size was small, Trowell et al. reported the effectiveness of psychodynamic therapy with female survivors of multiple traumas in addition to CSA including repetitive sexual abuse, multiple perpetrators and severe family dysfunction. Similarly, in a meta-analysis, humanistic therapies including client-centered therapy (CCT) have been considered to be as effective as CBT for child and adolescent survivors of CSA with sustained improvements found up to one year after treatment completion (i.e. Elliott, 2002).

Play therapy has received similar positive reviews. Greenspan et al. (2013), in a recent review, report that most studies supported the efficacy of Play Therapy. Although studies on play therapy for CSA are reported to be sparse (Scott, Burlingame, Starling, Porter, & Lilly, 2003), there is support for its use, especially in combination with other therapeutic approaches. For example, CCT has been shown to be effective in play therapy by Scott et al. (2003) and they reported an increase in sense of competency of children over time and during play therapy. Based on the review of literature, Springer et al. (2012) emphasize integrating play therapy techniques with other evidence-based treatments for CSA**.** Sánchez-Meca et al. (2011) also posit that the best results were found when TF-CBT was combined with supportive and a psychodynamic element, such as play therapy.

Other approaches such as art therapy (i.e. Pifalo, 2002; Pretorius & Pfeifer, 2010), drama therapy (i.e. Mackay, Gold, & Gold, 1987), and animal assisted therapies (AAT) including equine assisted therapy (i.e. Eggiman, 2006) and use of therapy dogs (i.e. Dietz et al., 2012; Reichert, 1994, 1998) have also showed positive results in active comparison studies for reducing symptoms and overall helping children recover from CSA trauma, however recommendations for structured empirical studies were emphasized. Besides providing symptomatic relief, these therapies are considered to facilitate disclosure of CSA by providing a child-friendly, safe and comforting therapeutic space (Eggiman, 2006; Reichert, 1994), however AAT is not considered to be appropriate for all children (Dietz et al., 2012).

Multiple psychological therapies.

Besides individual studies discussed above, some systematic reviews and meta-analyses have examined the effectiveness of multiple psychological therapies or a range of

psychotherapeutic approaches for CSA (though limited in number) with children and adolescents. These include meta-analyses (i.e. Cohen, Mannarino, Murray, & Igelman, 2006; Benuto & O'Donohue, 2015; Harvey & Taylor, 2010; Hetzel-Riggin et al., 2007; Sánchez-Meca et al., 2011; Skowron and Reinemann, 2005; Trask et al., 2011) as well as meta/systematic reviews (i.e. Coren et al., 2009; Finkelhor & Berliner, 1995; Greenspan et al., 2013; Jones & Ramchandani, 1999; O'Donohue, & Elliott, 1992; Saunders et al., 2003; Ross & O'Carroll, 2004) and other studies (i.e. New York City Alliance against Sexual Assault; NYCAASA, 2005). The therapeutic interventions reviewed included narrative therapy, play therapy, family therapy, CBT (including family CBT, child CBT, trauma focused CBT, group CBT), EMDR, child centered therapy, image rehearsal therapy, stress inoculation training, and supportive counselling/therapy, abuse specific treatment, art or drama therapy and no treatment. A combination of treatment modalities have also been studied (individual, family, group or mixed/combination). Broader inclusion criteria, beyond presenting and measurable symptoms, have been applied including variables such as behavior problems, psychological distress, social functioning, self-esteem, self-concept, coping skills and adaptation. One study also examined approaches in various settings such as research, agency, government or combination (i.e. Harvey & Taylor, 2010). These approaches included have not always been mutually exclusive, for example cognitive behavior, abuse focused, group therapy may be used together (Cohen et al., 2004).

All of the above meta-analyses and reviews conclude that therapeutic intervention is better than no treatment; however definite efficacy or superiority of any treatment method over the other has not been demonstrated. Reduction in symptoms of distress and psychological disturbance associated with CSA was found in the majority of studies following treatment irrespective of the therapeutic approach studied (i.e. Arvinger & Jones,

2007; Coren et al., 2009; Greenspan et al., 2013; Harvey & Taylor, 2010; O'Donohue & Elliott, 1992; Ross & O'Carroll, 2004; Skowron & Reinemann, 2005). Some researchers conclude that no therapeutic intervention exclusively or in combination with another intervention can be considered as a "gold standard treatment" for the range of symptoms associated with CSA for children and adolescents (Greenspan et al., 2013, p.233). Some multi-therapy studies found different approaches useful for specific outcomes. For example, eclectic and play therapy is reported to be most effective for social functioning difficulties (i.e. Hetzel-Riggin et al., 2007; Benuto & O'Donohue, 2015); abuse-specific, supportive therapy and group therapy for behavior problems (i.e. Hetzel-Riggin et al., 2007); cognitive-behavioral and individual therapy for reducing psychological distress including anxiety, depression, behavioral problems and PTSD in children and adolescents (i.e. Hetzel-Riggin et al., 2007; King et al., 2002; Passarela et al., 2010); art therapy and individual supportive therapy for facilitating emotional expression related to CSA (i.e. Sánchez-Meca et al., 2011); and CCT for treating problems related to self-esteem, self-concept and symptoms of depression (i.e. Scott et al., 2003). Supportive and directive approaches are preferred by some over the non-directive treatments as the silence involved in the latter is considered to cause avoidance, replicating the silence of the abusive experience (Ross and O'Carrol, 2004). Some suggest that the choice of therapy should depend on the child's main presenting secondary problem (Hetzel-Riggin et al., 2007). Practice of integrative approach, i.e. combinations of different therapies, is recommended in this regard (Greenspan et al., 2013). Involvement of non-offending parent(s)/safe carer is also considered beneficial by some (e.g. Harvey and Taylor, 2010), while others have not found added advantage of engaging them together with the child in therapy (e.g. Corcoran & Pillai, 2008; Passarela et al., 2010; Trask et al., 2011).

Pharmacological treatment.

Although no studies seem to have compared pharmacological treatment with therapeutic interventions (NICE, 2005; Passarela et al., 2010), the evidence-base for drug treatment in PTSD, including when caused due to CSA, is indicated to be limited (i.e. Cohen, Scheid, & Gerson, 2014; NICE, 2005, 2018). No such studies were found in this review as well. This is a significant aspect for further research.

Other trauma models for CSA-therapy and complex trauma.

This review also highlighted other RCT, non-RCT, and pre and post treatment design studies on diverse therapeutic models developed specifically for child and adolescent survivors of sexual abuse as well as for rape, sexual assault or complex trauma in children and adolescents in general. This reflects a focus on mixed or eclectic therapeutic practice, combining components of both structured/directive and more fluid/non-directive approaches, focusing on the needs and presentations of child survivors and their carer/safe parent. For example, one of the recent evaluation including qualitative case studies and largest RCT of a therapeutic intervention for CSA, i.e. Letting the Future In, revealed good evidence of its effectiveness with child survivors over eight years and young people (i.e. Carpenter et al., 2016). Letting the Future In is described as a structured guide to therapeutic intervention specifically for children affected by sexual abuse and their safe carer, which is largely psychodynamic in nature and also draws on other methods including counselling and socio-educative approaches (i.e. Carpenter et al., 2016). Similarly, non-RCT and pre and post treatment design studies on other therapeutic models in the past three decades have also provided evidence of improvement in child survivors and non-offending parents/caregivers post-treatment and at 1-2 year follow up. For example, Recovering from Abuse Program,

which is a structured experimental treatment program based on Traumagenic Dynamic Model (i.e. Finkelhor & Browne, 1985); the Attachment, Self-Regulation, and Competency framework (ARC) for complex trauma (i.e. Arvidson et al., 2011; Kinniburgh, Blaustein, Spinazzola, & Van der Kolk, 2005); and Integrated Treatment of Complex Trauma for Children (ITCT-C) (i.e. Lanktree & Briere, 2008, 2013) and Adolescents (ITCT-A) (i.e. Briere & Lanktree, 2008; 2013). In addition to these, other diverse therapeutic models for CSA-therapy with children and adolescents were found to be documented in literature but lack empirical evidence. Some examples include the Trauma Model (i.e. Herman, 1992), Resolution Model (i.e. Orenchuk-Tomiuk, Matthey & Christensen, 1990), and Internalization Model (i.e. Wieland, 1997, 1998). These models primarily suggest a stage-wise, sequenced and integrated approach with slight variations in all. However, not much information about the outcomes and evaluation of these models is available in literature. Further, mindfulness and meditation based models for people with histories of child abuse have also been highlighted, however most of them seem to have been practiced and evaluated with adult survivors (Earley et al., 2014; Hill, Vernig, Lee, Brown, & Orsillo, 2011; Kimbrough, Magyari, Langenberg, Chesney, & Berman, 2010).

4.2.3 Length of Treatment: Inconclusive Evidence.

Concerns have also been raised about appropriate length of the treatment and ways of standardizing the same (Greenspan et al., 2013). Some studies, including meta-analyses (e.g. Corcoran & Pillai, 2008; Hetzel-Riggin et al, 2007; Sánchez-Meca et al., 2011; Trask et al., 2011), individual studies by treatment developers (e.g. Lanktree & Briere, 2013) and independent evaluation studies involving RCT (e.g. Carpenter et al., 2016) report greater improvements in child and adolescent survivors with longer duration of therapy. For

example, Carpenter et al. (2016) found some evidence of reduction in clinical/significant difficulty in younger children at the 12 month follow-up, with no different between baseline and six month follow-up, suggesting that effects of the intervention may take longer to achieve; and even safe carer may take longer to notice improvement in their child due to their own trauma associated with their child's sexual abuse. On the contrary, treatments achieving symptomatic relief or outcomes quicker are considered to be more efficient, as it shortens the suffering of the child from symptoms and risks associated with CSA (i.e. Cohen et al., 2005). However, due to lack of consensus, it is considered crucial to ascertain the appropriate length of the treatment (Benuto, & O'Donohue, 2015) and effectiveness of "briefer, more intensive forms of therapy" compared with "a longer term, but less intensive, form of therapy" (Greenspan et al., 2013, p. 237). Researchers have also emphasized a need to examine the influence of a setting or facility on practice of therapeutic approaches as well as the length of treatment (Greenspan et al., 2013).

Summary: Evidence-base, Effectiveness and Gaps in Knowledge of Therapeutic Approaches.

- It is evident from the above findings that a wide range of therapeutic approaches are enumerated in literature for CSA trauma ranging from traditional, well known therapy approaches to newer, less known models. Some of them are well evaluated while others are not.
- The evidence of effectiveness of these approaches and models for CSA therapy with children and adolescents is inconclusive, and rather contradictory and controversial. Most studies recommend further research to examine specific benefits of different approaches and whether or not particular approaches lead to better outcomes (Harvey & Taylor, 2010).

Drawing conclusions about the effectiveness of therapeutic approaches in absence of comparison treatment groups is considered to be challenging (Greenspan et al., 2013). At the same time, it is speculated that no treatment program is perfect and there may be side effects associated with therapy for some children, such as worsening of symptoms, irrespective of the approach followed (Berliner & Saunders, 1996), however not much is known about it.

- Similarly, there are conflicting findings about therapeutic interventions involving non-offending parent(s) or safe carer, along with or separate from children and young people. There are studies that provide both kind of evidence, i.e. in its favor as well as against as mentioned earlier; and there is also a reflection that safe carer work may be particularly significant with young child survivors who may be more reliant on their carer (i.e. Carpenter et al., 2016).
- Last, but not the least, studies are also required, within different settings and facilities, to ascertain the effectiveness of briefer interventions compared with long-term therapies in order to ascertain appropriate length and duration of treatment.

Although little is known about the actual practice of various therapeutic approaches and models in applied, clinical settings, a shift in trend is being reflected through this review, highlighting a shift from structured approaches to therapy towards non-directive approaches and non-traditional models, or acceptance of a combination of both. For example, in the recent NICE guidelines (2017) for CSA, in addition to TF-CBT, other interventions are recommended, such as Letting the Future In, for child and young survivors of CSA (boys or girls aged 8 to 17) as well as individual focused psychoanalytic therapy or group psychotherapeutic and psychoeducational sessions for girls (aged 6 to 14) who have been sexually abused (NICE, 2017). Further, such intervention models and guidelines emphasize

the need for identifying and designing therapeutic interventions specifically for children and young people with sexual abuse experiences, separate from child maltreatment and other form of adverse childhood experiences, for e.g., as seen in the new NICE guidelines (National Guideline 76; 2017).

4.3 Therapeutic Modalities: Evidence-Base and Gaps in Knowledge and Practice

Frequent use of different modalities in therapy has been reported either exclusively or in combination (Lev-Wiesel, 2008). Few studies have specifically focused on effectiveness of different therapy modalities, including group, individual and family therapy in a combination of therapeutic approaches (such as CBT, psychodrama, CCT, psychodynamic and unspecified models). These include independent studies (i.e. Duffany & Panos, 2009; Gorey, Richter, Snider, 2001; Nolan et al., 2002; Liotta, Springer, Misurell, Block-Lerner, & Brandwein, 2015, Tourigny et al., 2005), meta-analyses (i.e. Reeker, Ensing, & Elliott, 1997), and a systematic review (i.e. Avinger & Jones, 2007).

4.3.1 Effectiveness of therapeutic modalities: inconclusive evidence.

This review highlighted a lack of consensus on the effectiveness of any one therapeutic modality over the other, including one-on-one or individual therapy, group therapy and family therapy for CSA with child and adolescent survivors. In a recent meta-analysis, it is noted that the effectiveness or superior treatment gains of individual, family, or group modality still need to be ascertained (i.e. Benuto & O'Donohue, 2015). Similar to the therapeutic approaches, the evidence for these treatment modalities is inconclusive and inconsistent (Ramchandani & Jones, 2003).

Few researchers report family-based and individual approaches to be more effective for trauma symptoms than group therapy (e.g. Harvey and Taylor, 2010). On the other hand, some studies support group modality as more effective than individual therapy for sexually abused children and adolescents (i.e. Arvinder and Jones, 2007; Duffany & Panos, 2009; Gorey et al., 2001; Reeker et al., 1997) and non-offending mothers (i.e. Duffany & Panos, 2009). A few therapy approaches are reported to be more effective when practiced in a specific modality. For example, Dietz et al. (2012) found AAT to be more effective in group settings. Similarly studies on CBT in groups (i.e. Deblinger et al., 2001) including a new approach introduced, GB-CBT (i.e. Misurell et al., 2011; Springer et al., 2012) report its greater benefits in group settings. Some consider group therapy to be a "frequently chosen method of intervention for child sexual abuse survivors" (Dietz et al., 2012, p.666) due to its benefits associated with peer support and feedback (Dietz et al., 2012), cost-effectiveness (Reeker et al., 1997; Tourigny et al., 2005; Misurellet al., 2011; Springer et al., 2012) and for preventing victimization and recidivism (Duffany & Panos, 2009). Outcome research on group therapy modality has been considered to be sparse and unreliable (Arvinder and Jones, 2007; Duffany & Panos, 2009).

Similar to therapeutic approaches, some researchers did not find a clear evidence of effectiveness or benefits of one modality over the other (Greenspan et al., 2013; Harvey & Taylor, 2010; Hetzel-Riggin et al., 2007; Nolan et al., 2002). Both individual and group therapy, practiced exclusively or in combination, have been reported to be equally effective in the treatment of the psychological sequelae of child, without clear statistical differences between the two regardless of the study design (Greenspan et al., 2013; Gorey et al., 2001; Nolan et al., 2002; Trask et al., 2011; Trowell et al., 2002) even at a follow up of 6 months or more (i.e. Nolan et al., 2002). Similarly, clear evidence of effectiveness of family therapy is

also missing. For example, Hetzel-Riggin et al. (2007) found low effect sizes for family therapy, which they report as being inconsistent with previous findings.

Summary: Evidence-base, effectiveness and gaps in knowledge of therapeutic modalities

- Overall, from the above discussion, it can be concluded that there is some support for each modality, including individual, group and family, irrespective of the psychotherapeutic approach practiced (Jones and Ramchandani, 1999); and there is a lack of consensus on the effectiveness of any one therapeutic modality over the other,
- All modalities have been found to be associated with positive changes (Skowron & Reinemann, 2005).
- Some therapy approaches are reported to be more effective when practiced in a specific modality, i.e. individual, group or family.
- Some recommend individual or group therapy to be used according to the age, and/or reactions of the survivors to the CSA-trauma experienced (e.g. Greenspan et al., 2013).

4.4 Overall Critique of Existing Empirical Studies on Therapeutic Interventions: Limited Scope and Methodological Flaws

Overall, a number of challenges and limitations of existing empirical studies have been noted that make it challenging to draw conclusions about effectiveness of therapeutic interventions for child and adolescent survivors of CSA from diverse backgrounds. These are discussed in this segment.

4.4.1 Limited scope: overemphasis on symptomatology and lack of developmental perspective.

One of the key critiques of extant studies on therapeutic approaches for CSA therapy with children and adolescents including RCTs and other study designs is that most of these are situated within the symptomatology or PTSD framework (King et al., 1999; Ross and O'Caroll, 2004). Overall, the scope of interventions documented in literature is reported to be limited, usually targeting fear, anxiety, low-mood and sexually inappropriate behavior (Macdonald et al., 2006). The studies are based on clinical samples of symptomatic CSA survivors who complete the treatment (Lalor & McElvaney, 2010). Further, it is reported that therapeutic interventions that are considered to be effective for CSA in existing studies, such as the cognitive behavioral approaches, were primarily developed for the treatment of post-traumatic stress symptoms caused due to different forms of traumatic episodes (Lev-Weisel, 2008), and not specifically for CSA. Hence, the focus of these interventions and their evidence-base seems to be strongest for PTSD-symptoms reduction (Macdonald et al., 2012).

PTSD is characterized by development of key symptoms following exposure to an extreme traumatic event (which includes sexual assault), such as flashbacks, dreams or nightmares, sense of numbness, emotional blunting, detachment from other people, unresponsiveness to surroundings, avoidance of activities and situations reminiscent of the trauma (American Psychiatric Association; APA, 2000). It is one of the outcomes associated with CSA in some children. 30-50% of sexually abused children meet partial or full PTSD criteria (Cohen, 2008; Kendall-Tackett, Williams and Finkelhor, 1993; Maikovich, Koenen, & Jaffee, 2009). However, PTSD has been critiqued as an adult-centered conceptualization being applied to children and adolescents (Cook, Blaustein, Spinazolla, Van der Kolk, 2003; Mullen & Fleming, 1998), and it is emphasized that "most current conceptualizations of

childhood PTSD are some distance away from a genuinely developmental approach" (Pat-Horenczyk, Rabinowitz, Rice, & Tucker-Levin (2009, p.62). The diagnostic criteria for PTSD is not considered sensitive to developmental factors, as it cannot explain the impact of prolonged or repeated abuse such as intrafamilial sexual abuse during different child and adolescent development stages (Connor & Higgins, 2008a, 2008b; Cook et al., 2003; Courtois, 2004; Herman, 1992; Mullen & Fleming, 1998). Further, it is difficult to measure PTSD symptoms in child and adolescent survivors as available instruments are reported to be of limited use with children (Cohen et al., 2008; Saywitz et al., 2000). Another key challenge in application of the PTSD model to children is regarding the difficulty in ascertaining pre-trauma functioning in children (Foa & Meadows, 1997). A significant feature of PTSD is that the symptoms represent a change from pre-trauma functioning, which is difficult to ascertain in childhood abuse survivors as many of them have not known a life without trauma (Foa & Meadows, 1997). The need for clearly inferring the degree to which these symptoms represent PTSD is highlighted before applying treatments recommended for it.

With growing research, it is being recognized that vulnerabilities and social situations associated with multiple traumatic experiences for children and young people require greater attention, management and interventions (Ramchandani and Jones, 2003) appropriate to their age and stage of experiencing trauma and seeking treatment. Within this context, children and adolescents exposed to multiple traumas (such as prolonged, repeated CSA, polyvictimization, and or other forms of prolonged social and interpersonal traumatic events) by one or more persons particularly within the care-giving system seem to be understood better within the complex trauma framework. The complex trauma conceptualization is informed by the developmental framework of children and adolescents, and encapsulates the dual problem of children's exposure to multiple traumatic events as well as the immediate

and long-term impact of trauma exposure (Cook et al., 2003), besides highlighting the significance of child's strengths, resilience and protective factors that can be enhanced through early intervention and therapeutic support (Seshadri, 2002). Considering the previous diagnostic and statistical manual (i.e. APA, 2000) guidelines did not appropriately address these complexities and the developmental impact of trauma on children and adolescents, a new diagnosis, 'developmental trauma disorder' has been introduced in DSM-V (i.e. APA, 2013). This includes sexual assault and is considered more appropriate for intrafamilial, early, chronic and multiple experiences of trauma (Greenspan et al., 2013; Sar, 2011). Difficulty in establishing a diagnosis is considered another challenge in comparing treatment approaches for child and adolescent survivors of CSA (Greenspan et al., 2013).

These aforementioned complexities are not reflected in most empirical studies that have assessed treatment outcomes and effectiveness of various therapeutic approaches for CSA (Cohen, 2008*).* Gender, age and development stage have not been adequately considered for treatment design (Harvey & Taylor, 2010), and age-specific therapeutic interventions including information on their benefits and effectiveness is lacking in current literature (Greenspan et al., 2013). Children and adolescents have been included as part of the same sample in most studies, although trauma impact and adaptation to treatments may vary significantly for them as they are at a different developmental phases (Passarela et al., 2010).

Further, concerns have also been raised about exclusion of diverse groups of children from existing empirical studies, such as asymptomatic child and adolescent CSA survivors, those who self-harm or cause harm to others (Berliner & Saunders, 1996; Lalor & McElvaney, 2010), those who do not disclose and/or those who withdraw their claims of CSA (Lalor & McElvaney, 2010). Early intervention is suggested for all child survivors depending on their needs, situation and presentations including those who are symptomatic,

asymptomatic or those who do not appear severely distressed (Berliner & Saunders, 1996; Colangelo, 2012), however these complexities of CSA survivors also do not appear to captured in existing studies. As a result, effective treatments for such child survivors are not known including the impact of CSA on them, their therapeutic needs and treatment outcomes (Lalor & McElvaney, 2010; Lev-Wiesel, 2008). Similarly, lack of details and clarity in the existing studies about the abuse characteristics including nature and frequency of sexual abuse, age of onset and time since abuse, and relationship to perpetrator has also been critiqued (Harvey & Taylor, 2010; Sánchez-Meca et al., 2011), as it limits the scope of assessing effectiveness of interventions and makes it difficult to draw conclusions about moderators of treatment (Harvey & Taylor, 2010).

4.4.2 Methodological flaws, geographic and demographic limitations.

The methodological limitations and inconsistencies in most of the current studies on CSA therapy have an impact on generalizability of findings, which in turn affects the ability to make robust conclusions about effectiveness of different treatment interventions. This critique has been presented for many studies, including controlled/RCT studies on CBT and TF-CBT (Macdonald et al., 2006, 2012), quasi-experimental or other study designs on different psychotherapies (Benuto & O'Donohue, 2015; Lalor & McElvaney, 2010; Sánchez-Meca et al., 2011), and treatment modalities such as group interventions (Nolan et al., 2002; O'Donohue & Elliot, 1992; Duffany & Panos, 2009). Comparing results between different studies is challenging due to the considerable variation in the specific outcomes measured (Greenspan et al., 2013; Benuto & O'Donohue, 2015; Macdonald et al., 2006, 2012). Further, details in existing studies about methodological strengths and limitations are lacking (Ross and O'Carroll, 2004).

Challenges with the process of evaluating the evidence-base itself are also emphasized in current literature. For example, RCTs are considered to be the gold standard. However, a recent review and synthesis of meta-analyses on treatment of sexually abused children identified only 23 RCTs (approximately 29%) out of 77 studies, included in seven meta-analyses reviewed (i.e. Benuto & O'Donohue, 2015). The need to tailor treatment specific to each child's response to sexual trauma experienced has been identified as a challenge in conducting RCTs with sexually abused children.

Further, most of the existing studies on different treatment interventions originate from the USA (Harvey & Taylor, 2010; Macdonald, 2006, 2012). Majority of the studies in a meta-analysis by Sánchez-Meca et al. (2011) were identified from North America (41 of the 51 groups), followed by Europe (5 groups), Oceania (3 groups), and least from Asia (2 groups). In addition, most existing studies lack demographic details about the participants including ethnicity and socio-economic status (Harvey & Taylor, 2010; Sánchez-Meca et al., 2011). Similarly gender has not been revealed in quite a few studies, while a number of studies have been conducted only with girls (Macdonald, 2006, 2012). These limitations pose challenges in replication of studies and in generalizing the findings to different social, contextual, cultural and gender groups. A need for accessible and culturally sensitive treatment options has been recognized as these factors are considered significant in determining recovery of children following CSA (Coren et al., 2009). One study (i.e. Jaberghaderi et al., 2004) that compared EMDR and CBT treatment with sexually abused girls in Iran concluded that structured treatments can be applied to children in Iran. Similarly, Weiner et al. (2009) found the cultural relevance of therapies in their pilot studies and they emphasized the need for flexible adaptations of treatment approaches to the construct of cultural competence. However such studies of cultural relevance are limited. Even in these

studies, small sample size was considered to be a limitation in drawing robust conclusions and a need for adding cultural assessment to evaluation protocols was acknowledged. However, little is known about treatment responses for CSA survivors specific to cultural, racial, ethnic, religious and gender identities, and need for further research in this area has been emphasized (Lalor & McElvaney, 2010; Saunders et al., 2003; Springer et al., 2012).

Summary: Overall critique of existing empirical studies on therapeutic interventions.

- Overemphasis on the symptomatology or PTSD framework and lack of developmental framework are among the key critiques of current studies on therapeutic interventions for CSA with children and adolescents.
- Information about therapeutic interventions appropriate to age and development stage of child and adolescents survivors is lacking in current literature, including understanding and studies about their benefits and effectiveness. Further, the development stage, age and gender of child and adolescent survivors as well as those with diverse presentations and needs have not been adequately considered for treatment design in most of the existing studies. Hence, there is a lack of understanding on effective treatments based on specific needs, characteristics and presentations of sexually abused children and young people.
- Methodological flaws and limitations in various studies, including small sample sizes, and geographic and demographic challenges, make it difficult to draw conclusions and generalize the findings.
- Research on therapeutic interventions for CSA survivors specific to cultural, racial, ethnic, religious and gender identities is lacking, and hence, not much is known about the socio-cultural relevance and appropriateness of existing interventions.

5. Conclusions

It is evident from the above review of extant literature that the effectiveness and evidence-base of therapeutic interventions currently used with child and adolescent survivors of CSA remains largely unaddressed and inconclusive. This includes the lack of evidence-base regarding various approaches to therapy, modalities as well as other aspects around the length and duration of treatment and efficacy of interventions in different country and cultural contexts involving child survivors with diverse needs and presentations. A range of treatment approaches with varying constructs itself pose challenges in drawing conclusions about their outcomes (Arvinger & Jones, 2007). At the same time, considering that a number of therapeutic approaches have demonstrated improvement in symptoms, it could indicate that symptom remission is not entirely dependent on the type of treatment received (Greenspan et al., 2013). Some researchers have attributed the variations in treatment outcomes across studies to the heterogeneity of CSA including interplay of diverse variables in abusive experience and therapeutic practices (Hetzel-Riggin et al., 2007; Reeker et al., 1997). For example, variations in specific group treatments, age of survivors, abuse related variables (i.e. the type, severity and length of abuse and the relationship of the child to the perpetrator), and child-related variables (such as the vulnerability factors, protective factors, resiliency of a child, and the reaction and support of the family). Further, it could indicate that symptom remission alone is not only and/or an adequate outcome by itself, and that perhaps personally meaningful outcomes are equally or even more important in recovery. This certainly has shown to be the case in adult survivors of CSA (Chouliara & Narang, 2017; Chouliara et al., 2013). Hence, given the heterogeneity of CSA and interplay of diverse variables, a significant recommendation worth consideration for further research and practice

is the need for diverse, individualized/tailor-made, client specific/child-centered, multimodal treatment and/or sequence and stage based approaches at different times in life depending on the developmental stage of child and adolescent survivors (Cohen, 2008; Coren et al., 2009; Harvey & Taylor, 2010; Hetzel-Riggin et al., 2007; Saunders et. al., 2003); with a combination of both structured/directive and non-directive approaches. These aspects require further understanding and research from perspective of the practitioners as well as child survivors and their carers as recipients and service users.

Research on most of the therapeutic interventions, including both approaches and modalities, for child and adolescent survivors of CSA is either non-existent or in its infancy, which contributes to conflicting, inconclusive and limited evidence on their effectiveness. Further, as reflected in this review, existing research seems fragmented and affected by methodological limitations including geographic and demographic limitations, small samples, age and gender variables, and considerable variations in the specific outcomes measured across studies. Hence, it is challenging to make robust conclusions about effectiveness of interventions and to generalize the findings to inform practice. Challenges with the methodology and process of evaluating the evidence-base itself have been identified in this review, including concerns around conducting RCTs with child and adolescent survivors of CSA. Greater research is required to evaluate the benefits, efficiency and effectiveness of therapeutic interventions including cost-effectiveness of one treatment compared with another (House, 2006; Macdonald et al., 2006; 2012) in different country and cultural contexts and with diverse groups of child and adolescents survivors using both quantitative and qualitative study designs and methodologies.

Despite the multiplicity of programs, including a range of generic and specialized CSA treatment approaches and models, there is lack of information on practice of these

interventions by professionals in in real/applied, clinical settings' as well as experiences of service users, both adults and children, with respective approaches. There is lack of research on how existing treatments might be effectively assigned to survivors of CSA (Lev-Weisel, 2008; Saunders et al., 2003). The key aim of the evidence-based framework is to ensure that the practice is informed by "research evidence" or is "grounded in evidence" (Webb, 2001, p.59; Warwick-Booth, Cross, & Lowcock, 2012). It is unclear what informs the therapeutic practice with child and adolescent survivors of CSA considering the absence of culturally-specific, clear guides to therapy for this population and inconclusive, rather conflicting and contradictory, evidence-base in all areas including the type of treatment for different forms of CSA-trauma (single episode vs. complex, multiple trauma), therapeutic modality (individual vs. group therapy), and length and duration of therapy (long-term vs. short term). It contributes to concerns that the "case management decisions and decisions about what techniques to be used in treatment are made by clinicians without empirically tested guidelines" (Lev-Weisel, 2008, p. 671). It could be the case that practice is largely based on clinical experience and judgment of practitioners, as in other related fields, such as suicide risk assessment (McClatchey et al., 2018). However, the expertise within communities of practice with regards to the range of documented therapeutic interventions is not reliably represented in the existing research and empirical studies with child and adolescent survivors of CSA (Coren et al., 2009). Over the past two decades, a need for engaging in a dialogue with professionals regarding their practice and theory, as well as conducting observational studies in 'real world' settings has been emphasized by some researchers in the field (e.g. Finkelhor & Berliner, 1995; Macdonald et al., 2012). Exploring lived clinical realities by involving practitioners is also considered a way of ensuring culturally attuned research (Dallos & Vetere, 2005). It reiterates the need to redefine evidence-base as well as to devise

different ways to study, measure and record efficacy and evidence-base for therapeutic practice by involving practitioners as well as child and adolescent survivors themselves within their practice and clinical settings.

Most importantly, by highlighting the specific impact of CSA and various examples of existing therapeutic interventions, including both traditional approaches and non-traditional models (such as the Letting the Future In) as well advances in clinical guidelines on CSA (such as NICE, 2017), this review reiterates the significance of identifying, designing and evaluating therapeutic interventions specifically for children and young people with sexual abuse experiences, separate from child maltreatment and other form of adverse childhood experiences.

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